MED - Children's Mental Health Waiver Retrieving Referrals and Scheduling

Purpose: The review coordinator (RC) retrieves referrals and scheduling assessment through ISIS.

Identification of Roles:

Target Case Manager (TCM) or Integrated Health Home Care Coordinator (CC) - submits request for Children's Mental Health Waiver.

Review Coordinator (RC) - reviews request for level of care decision.

Performance Standards:

- Complete 95 percent of level of care (LOC) determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for subsequent service reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure: After the application for Medicaid has been

completed and there is a waiver slot available the referrals for assessment and/or reassessment for Child Mental Health waiver (CMH) are sent to Medical Services from the income maintenance (IM) worker through the Individualized Services Information System (ISIS) work page.

Once a TCM or CC completes the assessment and/or reassessment with the member and family, the TCM or CC will forward the information to Medical Services by facsimile to 515-725-0931 and by completing the ISIS workflow milestones.

Step 1: The RC will log onto the ISIS system with Internet explorer. The ISIS application and database URL address is https://secureapp.dhs.state.ia.us/ISIS.
Step 2: The RC will be provided log on and password by the manager.

ISIS Log on Screen
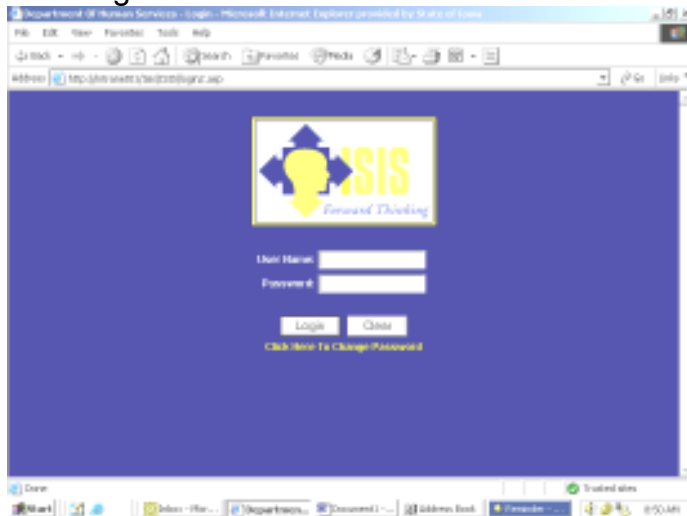
Step34: The RC will review the ISIS work page daily to retrieve referrals and to develop assessment schedule. Initial assessments will be completed within two business days of receiving the assessment and the mental health documents from the TCM or CC. Reassessments will be completed within five business days of receiving the assessment and the mental health documents from the TCM or CC. Arrival day of request counts as day zero.

Current ISIS workload is found by clicking on Consumer Tab and then My Workload.

Step 4: The RC will click on VIEW STATUS. The STATUS page displays steps already completed and the worker that completed each task.
   a. No workload items found indicates no key tasks require attention.
   b. The STATUS screen displays others involved in the case and their contact information.

c. When a member's case is added to the RC's workload, it will be placed at the top of the list alphabetically by date due.

d. The PROGRAM REQUEST on the expanded member record is an abbreviated form of the program request record that is found by clicking on the PROGRAM REQUEST tab after selecting a member.

Step 5: Once the workload has been identified, the RC will check OnBase, the IME electronic storage system for Medicaid documentation, for the assessment information corresponding with the member listed on the ISIS work page.

Step 6: The RC will review submitted documentation to ensure that the request is complete.

Step 7: The RC will complete a request for additional information in ISIS if needed. If the assessment information has not been received, the RC will respond to the ISIS milestone by selecting the statement, Assessment not Received. Review the functional assessment for the CMH Assessment form. The assessment for CMH is located on the website at http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

Forms/Reports:
N/A

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
ISIS
OnBase

Attachments:
N/A

MED - Children's Mental Health Waiver Completing Assessment Reviews

Purpose: The review coordinator (RC) retrieves referrals through ISIS and reviews assessments through OnBase.

Identification of Roles:
Review Coordinator (RC) – performs reviews of assessment information submitted by the TCM or CC.

Manager – provides program training and oversight. Provides consultation on review determinations and need for peer review.

Peer Reviewer (PR) – provides LOC determination for member's not meeting LOC criteria.

Targeted Case Manager (TCM) or Integrated Health Home Care Coordinator (CC) - completes the CMH Waiver Assessment Tool with the member and family members. The TCM also provides copies of diagnostic information and additional information upon the request of the RC.

Performance Standards:
- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for subsequent service reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure:
Step 1: The RC will review the assessment tool and the psychological and/or psychiatric information provided by the TCM or CC to determine waiver eligibility. Documents are stored in OnBase, and when necessary, supplemental information may be available within CMH Waiver on dhsime/Client Files/<Name of member>.

Step 2: Following are the possible outcomes of the assessment:
a. Psychiatric Hospital LOC criteria met
b. Psychiatric Hospital LOC criteria not met, refer to peer review

Step 3: The case information is tracked by the RC on an Excel spreadsheet located in the CMH waiver file under waiver tracking. The information tracked includes:
a. Member's last name
b. Member's first name
c. Member state identification (SID) number
d. Date of Birth
e. Coordinator's initials
f. Date of request for assessment received in Onbase.
g. Date assessment completed eligibility decision for LOC
h. Number of days to review
i. Five days Yes/No
j. Assessment Determination (A/D)
k. Denial Reason
l. Initial or Review
m. Primary Diagnosis

Step 4: Within two business days of the completed review assessment, the RC will enter in ISIS the LOC determination on the member's assessment status screen.
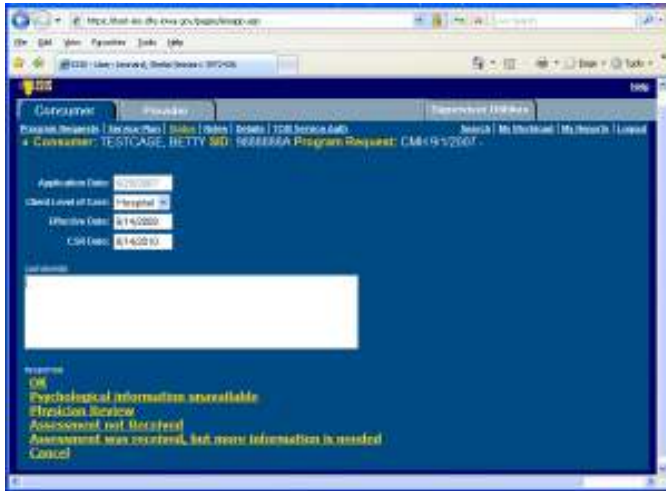
Step 5: On the WORKLOAD screen, the RC will select LOC key task milestone and click on respond button to access the LOC screen.

Step 6: The RC will enter Client LOC of Hospital, along with an effective date and a date for a CSR. Click OK at the bottom of the page.

Step 7: If member does not meet LOC, choose Denied under Client LOC.

    a. Denied means the member does not meet the LOC.

Step 8: Physician Review: Select when the case is referred for peer review.

Step 9: Assessment Not Received: Select when the assessment information was not received from the TCM or CC.

    a. Only information that is necessary to approve the service may be requested.

Step 10: If after appeal, the denial is reversed, the IM worker will be notified to repend the case in ISIS if the reconsideration or appeal occurs.

    a. The Department of Human Services (DHS) slot manager also needs to be notified to re-open a slot for the member.

Step 11: Effective Date: Enter the date the LOC becomes effective.

Step 12: Subsequent Service Review (SSR) Date: Enter the date chosen for the CSR.

    a. If an entry is not made, the CSR Date will default to one year after the entered Effective Date.

    b. If denial case has been reversed, the CSR date needs to reflect a one year time frame from when the assessment was completed.

Step 13: Comments: Allows text entry of information that will be useful to others who will be involved in processing this case.

Step 14: OK Response: Submits answers chosen above.

Step 15: Cancel Response: Postpones the response.

Step 16: Medicaid members meeting LOC for waiver services will be authorized for a period of one year.

Step 17: The RC will enter next review date into ISIS to generate next review date notification for 365-day reassessment.

Forms/Reports:

N/A

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
ISIS
OnBase

Attachments:
N/A

MED - Children's Mental Health Review Level of Care Criteria Met

Purpose: Complete the review of the assessment information to determine LOC for members.

Identification of Roles:
Review Coordinator (RC) – completes LOC reviews consistent with criteria.

Manager – provides program training and oversight. Provides consultation on review determinations and need for peer review.

Targeted Case Manager (TCM) or Integrated Health Home Care Coordinator (CC) - completes the CMH Waiver Assessment Tool with the member and family members. The TCM also provides copies of diagnostic information and additional information upon the request of the RC. Complete notice of action for CMH services.

Performance Standards:
- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for subsequent service reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure:
Step 1: The RC determines if the documentation received from the TCM is consistent with CMH LOC criteria.
> a. A member must meet all of criteria Sections I, II, and III to meet the LOC required for the Home and Community Based Services (HCBS) CMH Waiver.

Criteria
I. Member presents with a serious emotional disorder (SED) as supported by the current Diagnostic & Statistical Manual for Mental Health Disorders (DSM)

diagnostic criteria. Serious emotional disturbance shall not include developmental disorders, substance-related disorders, or conditions or problems classified in the current DSM-IV as other conditions that may be a focus of clinical attention (Zcodes) unless they co-occur with another diagnosable SED. The member does not present with a mental retardation diagnosis. A substance abuse diagnosis alone is not sufficient for involvement in the CMH Waiver program.

II.   Level of Stability must meet all of the following:
   a) The member demonstrates a risk to self and/or others but can be managed with services available through the CMH Waiver.
   b) The member demonstrates the ability to engage in activities of daily living but lacks adequate medical/behavioral stability and/or social and familial support to maintain or develop age-appropriate cognitive, social and emotional processes.
   c) The member is medically stable but may require occasional medical observation and care.

III.   Degree of Impairment must meet A and either B or C.
   a) The member has impairment in judgment, impulse control and/or cognitive, perceptual abilities arising from a mental disorder that indicate the need for close monitoring, supervision and intensive intervention to stabilize or reverse the dysfunction.
   b) Social/Interpersonal/Familial - The member demonstrates significantly impaired interpersonal functioning arising from a mental disorder that requires active intervention to resume an adequate level of functioning.
   c) Educational/Prevocational/Vocational - The member demonstrates significantly impaired educational and/or prevocational/vocational functioning arising from a mental disorder that requires active intervention to resume an adequate level of functioning.

Step 2: The RC will enter the LOC along with an effective date and a date for a Subsequent Review.

Step 3: The RC will select in ISIS OK Client LOC: Select the correct LOC from the pull-down menu.

Step 4: The RC updates the CMH waiver tracking spreadsheet.

Step 5: Upon approval of CMH LOC, the TCM or CC and interdisciplinary team identify services to meet the identified needs of the member.

Step 6: The TCM or CC is responsible for completion of a notice of decision to the member.

Step 7: Approval decisions are made in writing by the TCM or CC.

Step 8: The TCM or CC will mail a letter to the member, member's parent or guardian listed on the front page of the CMH waiver assessment tool. The TCM or CC is responsible to provide timely notice.

Step 9: If needed, approval decisions can be reversed if additional information is received that contraindicates continued approval.

   a. A request by email will be sent to the IM worker regarding the change in status requesting a change within the ISIS workflow milestones.

   b. A request will be made to have the review within OnBase returned to the RC's workload to change the status indicator on the case.

c. The RC will update OnBase and ISIS to reflect any change in decision and update the tracking log of the status change. d. Additional comments will be entered within the comment section of ISIS regarding the reason for the change in decision.

e. The TCM or CC will re-issue a notice of decision letter to the member.

Forms/Reports:
N/A

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
ISIS
OnBase

Attachments:
N/A

MED - Child Mental Health Waiver Assessment Level of Care Not Met

Purpose: When the RC is unable to determine a LOC, the RC will begin the peer review (PR) process to obtain a physician and/or consultant review for LOC determination.

Identification of Roles:
Review Coordinator (RC) – requests physician and/or consultant review for LOC.

Review Assistant (RA) – provides program support.

Manager – provides direction on need for peer review.

Peer Reviewer (PR) - completes review in accordance with medical criteria, provides reason and rationale for any denied reviews.

Performance Standards:
- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure:

Step 1: The manager will review the information to determine if the LOC request requires a consultant or PR. Only peer reviewers make denial decisions. Peer reviewers include licensed health care professions in the same category as the attending provider. Denials made by the CAMD will be reviewed by the MMD or other licensed physician. Refer to MED Administrative Functions Peer-to-Peer Conversations for details on this procedure.

Step 2: If the assessment is sent to PR the RC will pend the case in ISIS until the PR decision is obtained.

> a. The RC will open ISIS.
> b. The RC will click on the WORKLOAD page.
> c. The RC will click on Consumer tab.
> d. The RC will click on status.
> e. The RC will click on respond in the select LOC milestone.
> f. The RC will select option Physician Review
> g. The RC will use the text box on the status page to data enter, physician review requested.
> h. The RC will complete the PR worksheet and Physicians Rationale Form with pertinent information.
> i. The RC sends the PR completed assessment tool; mental health documents from Onbase; and PR forms.

Step 3: If a LOC request has not returned from the PR within two business days. The RC will contact the PR regarding the status of the review.

Step 4: When the PR review is completed, the RA locates the Physicians Rationale form in the OnBase logging queue. The RC will complete the Peer Review task and attach the peer review rationale to the already received documentation.

Step 5: The RC will click on complete after all information is documented in OnBase and result documented in ISIS.

Step 6: If the PR results in approval for LOC, the RC will follow the procedures outlined for LOC met.

Step 7: If the PR results in denial determination, the RC will document the denial in ISIS. All denials require a principle reason and clinical rationale of why the member was denied in the comments section for the milestone.

Step 8: The RC will choose denied in the LOC of care choice in ISIS.

Step 9: Denial and modification decisions are made in writing by NOD issued by the TCM or CC and sent to the member. The written notice must include the principle reason and the clinical rationale for the decision. Appeal rights are included in the notice.

Step 10: The RC will document the PR under the physician review tab in On Base.

Step 11: The member is notified of the denial determination from NOD issued by the TCM or CC. Medicaid providers may request a peer to peer consultation with the peer who made the adverse decision. They are informed of this option through Notice of Decision letters and through the IME provider website, Important Provider Announcements at http://www.ime.state.ia.us/Providers/index.html. Refer to MED Administrative Functions Peer-to-Peer Conversations for details on this procedure.

Forms/Reports:

Iowa Medicaid Enterprise-Medical Services
Peer Review Worksheet for CMH

Child's Name: State ID #:   Date

The child must meet all of criteria Sections I, II, and III to meet the level of care required for the HCBS Children's Mental Health Waiver.

Criteria	Comment (indicate met or describe concern)
I. Member presents with a mental disorder as supported by the DSM diagnostic criteria. He/she does not present with a mental retardation diagnosis. A substance abuse DX alone is not sufficient for involvement in the Children's Mental Health Waiver program	
II. Level of Stability (must meet **all** of the following):	
a) The member demonstrates a risk to self and/or others but can be managed with services available through the Children's Mental Health Waiver.	
b) The member demonstrates the ability to engage in activities of daily living but lacks adequate medical/behavioral stability and/or social and familial support to maintain or develop age-appropriate cognitive, social and emotional processes.	
c) The member is medically stable but may require occasional medical observation and care.	
III. Degree of Impairment (must meet **a** and **either b** or **c**).	
a) The member has impairment in judgment, impulse control and/or cognitive/perceptual abilities arising from a mental disorder that indicate the need for close monitoring, supervision and intensive intervention to stabilize or reverse the dysfunction.	
b) Social/Interpersonal/Familial – The member demonstrates significantly impaired interpersonal functioning arising from a mental disorder that requires active intervention to resume an adequate level of functioning.	
c) Educational/Prevocational – The member demonstrates significantly impaired educational and/or prevocational/vocational functioning arising from a mental disorder that requires active intervention to resume an adequate level of functioning.	

CMH Waiver/Peer Review/Peer Review Worksheet 6-13

Children's Mental Health Waiver
Physician Rationale Form

1. Review the case
2. Document your principle reason and clinical rationale in writing
3. Sign, date, and record your time
4. Return to Medical Services by _____

Child's Name: CMH: SID: DCN:____
Physician Reviewer Decision (check one):   Approve   _____
                                                Deny   _____

Please provide specific principle reason and clinical rationale for your decision:

_____
_____

_____

_____

_____

_____

_____

_____

Please indicate amount of time spent reviewing this case:

_____

If you have any questions, contact <RC Name> at 515-974-<XXXX> or by fax at 515-725-0931.

SIGNATURE _____ **DATE** _____

Form/Reports:

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
ISIS
OnBase

Attachments:
N/A

MED - Children's Mental Health Waiver Level of Care Determination Lack of Information

Purpose: If the review coordinator (RC) is unable to determine LOC due to a lack of information, the RC will request necessary additional information that the case manager can provide that was not provided in the assessment documentation.

Identification of Roles:
Review Coordinator (RC) – when needed will contact the targeted case manager (TCM) or Integrated Health Home Care Coordinator (CC) that filled out assessment document.

Review Assistant (RA) – will forward to RC any additional information that is faxed in.

Performance Standards:
- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure:
Step 1: The RC will contact the TCM or CC by ISIS to request additional information.

a. If the TCM or CC provides additional information, it can be taken over the telephone by the RC, emailed or faxed in as described below. Only information that is necessary to approve the service may be requested.

Step 3: The TCM or CC may also fax the additional information into Medical Services at 515-725-0931.

Step 4: The RC will track the request date and provide follow-up to ensure the information is received promptly so the review of the assessment can be completed within the required time of the referral for services. When the information is received the RC will complete the review of the assessment following the notification and documentation procedures outlined above. The RC may proceed to PR, with manager approval, upon receipt of requested documentation.

Step 5: When the assessment and/or mental health documents are not received, the RC will enter into ISIS:

a. Assessment Not Received: Select when assessment is not received from the TCM.
b. Psychological Information unavailable mental health documents were not received.
c. Assessment was received, but more information needed.

Forms/Reports:
N/A

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
ISIS
OnBase

Attachments:
N/A

MED - Child Mental Health Waiver Business Disruption Plan

Purpose: To provide procedures for the continuation of business in the event of inability to utilize electronic programming. The RA will receive LOC assessment documentation by fax, if available, or telephone.

Identification of Roles:
Review Coordinator (RC) – responds to LOC requests. All activities will be noted on the manual tracking log.

Review Assistant (RA) – receives LOC request and routes to the appropriate RC.

Manager – provides training and oversight in the field, tracks performance standards, produces reports for medical services and conducts internal quality control for review decisions.

Performance Standards:
- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure:
Step 1: The RA will receive assessment referral and will forward the request by telephone to the RC based on the criteria established by the manager.
Step 2: The RC will log calls and capture the following information:
    a. Date received
    b. Member name
    c. SID
    d. Caller name
    e. Services requested
    f. RC assigned
Step 3: The RC will document requests for assessments in a paper tool:
    a. Date Received
    b. Member Name
    c. SID
    d. Type of program request
    e. Date additional information requested
    f. Date additional information received
    g. Date of PR
    h. Status of request
Step 4: The RA will complete call log paper tool.
Step 5: The RC will document review information following the LOC review outline.
Step 6: The RC will enter review information in OnBase and ISIS when systems are restored.
Step 7: The RC will document compliance with criteria by using paper copies of criteria utilized for internal quality control (IQC) process.

Forms/Reports:

Date received	Date /Time RC contacted	Member name	Member State ID	Caller Name	RC assigned	Services Requested

Step 8: The RC will complete the paper tool.

Date Received	Member Name	Member ID	Service Requested	Date additional information requested	Date information received	Date of PR	Status of Request

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
ISIS
OnBase

Attachments:
N/A

MED - Children's Mental Health Waiver Appeals Process

Purpose: A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the notice of decision letter by contacting the local DHS office, by writing a letter to DHS Appeals Section or by filing on line at http://dhs.iowa.gov/appeals/appeal-a-dhs-decision. The notice of action letter contains instruction on how to request an appeal. Medical Services provides testimony for assigned appeal hearings.

Identification of Roles:
Manager - Receives appeal notice and responds in accordance with Med Srv Policy Support Appeals

Performance Standards:
- Performance standards are not specified for this procedure.

Path of Business Procedure: A notice of appeal rights is provided with each notice of adverse action. Notices of appeal rights include timeframes for filing a formal appeal. DHS requires that Medical Services not provide a formal reconsideration or first level appeal. If new information is submitted by the member or provider following the adverse action or with the formal request for appeal, Medical Services' review staff will review the information and decision and approve the service if medical necessity criteria are met. Additional information regarding a service that is a non-covered service will not be considered. If the requested service continues to not be supported by the submitted documentation, Medical Services' review staff will secure additional peer review. Since this is an informal process, it is not necessary to obtain a peer reviewer other than the one who made the initial decision. It is also not necessary to send a second notice of an adverse decision if the service does not meet medical necessity criteria.

Upon filing a formal appeal, members or providers will be informed of the certification of the appeal by DHS Appeals Section. For specific operational procedures related to

appeals completed by Medical Services on behalf of DHS, see MED Policy Support Appeals at IME Universal/Operational Procedures/Medical Services.

Only peer reviewers make denial or adverse decisions. Denial or adverse decisions are made in writing by the notice of action(NOA) issued by the DHS. Peer reviewers include licensed health care professions in the same category as the attending provider. Denials made by the Clinical Assistant to the Medicaid Medical Director (CAMD) will be reviewed by the Medicaid Medical Director (MMD).

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
ISIS
OnBase

Attachments:
N/A

MED - Children's Mental Health Waiver Urgent Requests

Purpose: The review coordinator (RC) will discuss with their manager and log the request.

Identification of Roles:
Review Coordinator (RC) – enter urgent care request in Individualized Services Information System and urgent request tracking log.

Manager- Report the number of urgent care requests and timeliness quarterly to corporate Utilization Review Accreditation Committee (URAC) compliance staff.

Director- Ensure the percent of timely urgent request are reported on the URAC compliance dashboard quarterly.

Path of Business Procedure:

Step 1: Urgent requests for prior authorization of services will be reviewed and a decision rendered and communicated in no less than 72 hours from receipt of the request.

Step 2: A request is urgent if the situation poses an immediate threat to the health and safety of the Medicaid member or if the attending physician, member or family member (someone with knowledge of the member's medical condition) indicates that the need is urgent and would jeopardize the health of the member if the review was completed in non-urgent timeframes. This time frame includes holidays and weekends.

Step 3: When an urgent request is received, the staff member will confer with manager and log the request on the spreadsheet located at MedSrv/Urgent Requests/Urgent Request Tracking.

Form/Reports:

Urgent Request Tracking

Program	Review Coordinator	Member L. Name	Member F. Name	SID	Requestor	Initial Date of Service	Date & Time of Request	Decision	Date & Time of Decision	No. of Hrs.	Notes

RFP Reference:

N/A

URAC Standard:

HUM 17

Interfaces:

N/A

Attachments:

N/A

MED - Children's Mental Health Waiver Internal Quality Control

Purpose: Internal quality audits ensure consistency and quality of review activity. The internal quality control (IQC) process is a peer-to-peer review process completed on a percentage of level of care (LOC) reviews from the previous month.

Identification of Roles:

Manager or Quality Improvement Facilitator (QIF) - Completes selected reviews for IQC process, enters results into spreadsheet, takes concerns or inconsistencies to review coordinator and completes IQC for appeal requests. Coordinates IQC and IQC reporting, determines percentage of reviews for IQC, reviews for inconsistencies.

Review Assistant (RA) or QIF – Selects random sample pull of IQC reviews for internal quality review.

Performance Standards:
- Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: The manager will manually select a percentage of completed reviews based on the number of LOC reviews completed in the previous fiscal year, divided out to be reviewed monthly.
Step 2: By the fifth business day of the month, using a random sample selection method, the RA or QIF will pull reviews from the monthly waiver report.
Step 3: The manager will determine the number of reviews; admission reviews and CSR reviews.
Step 4: The Internal Quality Control Questionnaire will be completed on each review.
Step 5: Based on the results of the questionnaires, the Manager will identify concerns and training issues and provide feedback to staff.
Step 6: The RC will correct any errors made during the assessment review process within three business days of detection.
Step78: The results of IQC will be documented in a spreadsheet located on the CMH/IQC/year/CMH IQC Report YEAR share drive and available upon request to DHS policy staff.

Form/Reports:

CMH Waiver IQC Questionnaire

Reviewer's Assigned Letter: Date: Member's Name:
Review Coordinator:

Question	(Yes, No, NA)	Comments
1. Does the documentation support the conclusion within Section I defined by eligibility criteria for serious emotional disturbance (SED)?		
2. Does the documentation support the conclusion with Section II - Level of Stability as defined by the eligibility criteria?		
3. Does the documentation support the conclusion with Section III - Degree of Impairment as defined by the eligibility criteria?		
4. Does the documentation support the assessment LOC decision?		

IQC Results – Member Mental Health Waiver Services Month_____					
Number of Total Authorizations for Review Month	Number of Authorizations Reviewed	Percent of Total Authorizations Reviewed	Percent of Agreement about need for additional information	Percent of Agreement on Decision	Percent of Accurate ISIS Entry

Reponses	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
Item 1												
Item 2												
Item 3												
Item 4												
Date of Team Discussion												

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
ISIS
OnBase

Attachments:
N/A

MED - Children's Mental Health Waiver Reports

Purpose: To meet all performance standards and complete all required reports.

Identification of Roles:

Manager or Quality Improvement Facilitator (QIF) –Tracks and reports performance standards, updates manual and completes reports.
Program Specialist-Responsible to proof, query reports/data, and complete quarterly and annual reports.

Performance Standards:

- Submit quarterly report to DHS by the tenth business day of the month following end of quarter.

Path of Business Procedure:

The manager or QIF will monitor performance standards data monthly and provide information to the staff. Performance standards to be monitored include:

a. LOC reviews and subsequent service review shall be completed for 95 percent of the members within five working days.
b. Enter LOC reviews and subsequent service review requests requiring a peer review, into ISIS within three working days of completion
c. Update the manual within three working days of DHS approval of a change or DHS request for a change.
d. Identify and correct any errors on the pre-screening assessment within three working days of the error detection.
e. Complete reports as required in Section 3.2.2.9.6 of RFP MED-10-001 pursuant to DHS standard guidelines.

Monthly Report
Step 1: The manager or QIF will access ISIS management reports and clinical data documented in OnBase and the CMH tracking log stored in CMHW>Waiver tracking>Monthly Tracking for 20XX to report the following monthly:

a. Number of initial assessment reviews completed by program
b. Number of assessments Approved
c. Number of Assessments Denied
d. Denial Reasons
e. Number of LOC and subsequent service reviews completed timely

f. Number of LOC and subsequent service reviews pended and pended reasons

Step 2: The manager or QIF will record specific data into "Working CMH Waiver Report by Month MO-YR to MO-YR" which is saved in CMHW>reports>Monthly Reports.

Quarterly Report

Step 1: The manager or QIF compiles quarterly report and other ad hoc reports as requested. The quarter's monthly data is compiled and entered into the quarterly report form.

Step 2: The manager or QIF will access quality review data from Onbase. This information is found in Report Services under Report Groups-ALL. Scroll down to locate MED QA timeliness. Save as an Excel spreadsheet, sort by CMH QA reviews. Delete all other types of QA Waiver Reviews. Save in CMH>Reports>QA Report Pull from Onbase Mo-Mo 20XX. Data regarding completed reviews, compliance met, concerns noted, and feedback provided is reported.

Step 3: The results of IQC are documented in a spreadsheet located on the CMH/IQC/year/CMH IQC Report YEAR share drive. The quarter's monthly data is compiled and entered into the quarterly report form.

Step 4: Data is proofed by the manager and program specialist prior to submission to DHS Policy by the tenth business day of the month following the end of the quarter.

Annual Report

The manager or QIF will prepare an annual report comparing assessment activity from one fiscal year to the next. The annual report will document cost savings as a result of adverse actions related to CMH Waiver review.

Step 1: The manager or QIF will review denied LOC reviews for past fiscal year. All appeals which have been reversed by the Administrative Law Judge will be identified. Cases that are initially denied and later reversed through appeal are excluded from the cost savings calculations.

Step 2: To calculate cost savings for care reimbursed on a per diem basis, the average length of stay (ALOS) information from Medicaid Management Information System (MMIS) database and reimbursement information from MMIS B-1 reports for prior SFY are utilized. The program specialist will provide the MMIS B-1 report to the manager or QIF for CMH Waiver. The numbers of upheld denials is multiplied by ALOS and the average cost per member for CMH Waiver.

Step 3: Upheld denials times ALOS months times average cost per member per month will equal fiscal year cost savings. Targeted Case Management costs for same will also be included within the annual cost savings report.

Form/Reports:

Total Number of Assessments Complete	Number of Initial Assessments and Reassessments	Number Approved	Number Denied	Untimely Auth Count	Percentile Timely	Denial Reason	Number Pending	Diagnosis on Approvals

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
ISIS
OnBase

MED - Long Term Care Waivers Quality Assurance Review Member Information Request

Purpose: To review the Medicaid member's interdisciplinary team records, and address the following desired outcomes:
a. Service plan developed and implemented toward a positive outcome
b. Necessary health, safety and welfare needs are monitored
c. Services identified need for approved level of care

Identification of Roles:

Review Coordinator (RC) – will complete a quality assurance interdisciplinary review of all information received.

Program Specialist – will manage the ongoing functions of quality assurance database.

Review Assistant (RA) – will support the RC with duties including mail merge, stuffing letters, taking letters to mailroom for stuffing, printing of letters and final tools.

Quality Improvement Facilitator (QIF) – will complete IQC reviews on QA sample monthly

Manager – will monitor database, all staff, process, process data, review outcomes, coach staff and answer questions.

Performance Standards:

- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure:

Step 1: The list of members' interdisciplinary team records to be reviewed each month will be submitted to the OnBase staff.

Step 2: The CM and/or SW and specific provider(s) will be sent a letter requesting information using names and addresses from ISIS.

Step 3: The RA will mail second request letter to those TCM, CM, or SW provider(s) who have not submitted information within 15 business days.

   a. Medical records and/or documentation received at IME facility from providers at the front desk, through a fax or the mailroom will be electronically scanned and forwarded to the RC upon arrival.

Step 4: Compact Discs of information will be forwarded to the RA to batch together and import into OnBase and then forwarded to the RC.

Step 6: The RC will not begin the quality review until all providers who have been requested to submit information submit the requested records.

Forms/Reports: First and Second Request letter

Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

[REQUEST_NUMBER] REQUEST

[Worker_Name]
[Worker_Addr]
[Worker_City], [Worker_State] [Worker_Zip]

RE: [Member_Name]   SID# [State_ID]

The Iowa Medicaid Enterprise (IME) Medical Services Unit conducts quality reviews of waiver provider records under contract with the Iowa Department of Human Services. The purpose is to perform a comprehensive quality review of all services received by randomly selected Medicaid members.

Do not send original documents. Please submit copies of [Member_Name_2] records for the dates of [Begin_Date] through [End_Date], including:

- Waiver assessment tool
- Comprehensive assessment
- Service plan
- Crisis plan
- Safety plan
- CDAC agreement

- Contact records
- Documentation regarding referrals and follow-up
- Documentation supporting identified level of care
- Incident reports
- Goals and outcome documentation

Use this request as your face sheet to better process your information. This information should be received by IME within fifteen (15) business days from date of this request. Documentation should not include paper clips, staples or highlighting. Information should be faxed or mailed to:

Iowa Medicaid Enterprise
[Unit_Name]
P.O. Box 36478
Des Moines, IA 50315
Fax number [Fax_Number]

Information can also be submitted on compact disc (CD) in PDF format only. Your cooperation in submitting the member's record for review is mandated by the Department of Human Services. [Contact_Info]

Iowa Medicaid Enterprise
Medical Services

cc: [Worker_Supervisor]

Reference #: [Reference]

A copy of this letter must be included as the first page of your documentation.

470-4964 (8/10)

Iowa Medicaid Enterprise – 100 Army Post Road - Des Moines, IA 50315

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
N/A

Attachments:
N/A

MED - Quality Long Term Care Waivers Quality Assurance Review Completion

Purpose: To review supporting documentation supplied from providers.

Identification of Roles:
Review Coordinator (RC) – will complete the quality review.

Performance Standards:
- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days. Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days

Path of Business Procedure:
Step 1: The RC will utilize the member's record to complete the identified measures located in the quality tool.
Step 2: The RC will review all of the records submitted by the providers as an interdisciplinary team review.
Step 3: The RC will complete one tool, and the same tool will be submitted to all the providers who submitted records.
Step 4: The RC will review the records to answer each quality component in the Waiver Quality Tool.
Step 5: The RC will evaluate and look for the following items:
   a. Member's individualized safety risks are identified.
   b. Intervention(s) to address safety risks are in service plan.
   c. Documentation indicates the adult member takes nine or more over the counter and prescription medications; OR documentation indicates the child member takes five or more over the counter and prescription medications; AND the

physician is aware.
d. Member had diagnosis or rationale documented for each medication taken.
e. Documentation of a major incident reflects submission to DHS
f. Documentation supports level of care determination.
g. Services received reflect level of care determination.
h. LOC completed in the last twelve months.
i. Service plan addresses the member's needs.
j. Service plan implemented as written.
k. Evidence of team communication regarding services coordinated by TCM, CM, or SW.
l. Member is meeting goals as written.

Step 6: The RC and QIF record information as specified on the waiver form in OnBase.

Step 7: Staff must give a score and a rationale for the score based on set number one on the access database form.

Step 8: This is a sample of the form that the RC will use to enter the informationn in OnBase.This is a partial picture of the form, the RC will scroll down to complete all areas of the form.

Step 9: The outcome of the quality assurance review will be included in a follow-up letter with quality tools attached and mailed to the CM and/or SW and provider(s) within 30 calendar days by the RA.
a. If a provider does not supply documentation for a review then the provider will receive the following letter.

Forms/Reports: SAMPLE final letter and tool described in next section, if records were submitted:

Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

[Prov_Name]
[Prov_Addr]
[Prov_City], [Prov_State] [Prov_Zip]

RE: [Member_Name] SID# [State_ID]

Dear Waiver Provider:

The Iowa Medicaid Enterprise (IME) Medical Services Unit conducts quality reviews of waiver provider records under contract with the Iowa Department of Human Services. The purpose is to perform a comprehensive quality review of all services received by randomly selected Medicaid members. The review results are shared with all providers that submitted documentation as part of the quality review. Enclosed is the completed review.

[Contact_Info]

Iowa Medicaid Enterprise
Medical Services

Enclosure

470-4967 (8/10)

Iowa Medicaid Enterprise – 100 Army Post Road - Des Moines, IA 50315

Measure	Scoring Set	Set 1 - Used for scoring Set 2 - Optional additional comments or education that can be provided Set 3 - Remediation for those that score a "No"
QC1A Service plan addresses the member's assessed health risks	Set 1	**QC1A** All assessed health risks were addressed. – Yes
		Not all assessed health risks were addressed. – No Documentation was not provided to IME that identifies health risks. – No Documentation provided and no health risks were identified on assessment; member has notable health risks.– No
	Set 2	Service plan needs to be updated and include information about identified health risks. Assessment does not contain a health risk section.
	Set 3	Recommend health risks be reviewed and interventions put into place. Recommend health assessment be completed and findings documented in the service plan.
QC1B Service plan has intervention/s to address assessed safety risks.	Set 1	**QC1B** All assessed safety risks were addressed on service plan.– Yes
		Not all assessed safety risks were identified on service plan. – No Safety risks were not identified on service plan. – No Safety plan documentation not provided to IME. – No
	Set 2	Safety risks identified in assessment were not addressed in a safety plan. Safety risks identified in provider documentation, were not addressed in safety plan. Service plans must address the member's saftey risks.
	Set 3	Recommend safety assessment be completed and findings documented in the service plan. Recommend service plan be updated to include interventions for all safety risks that are identified. Recommend safety interventions be documented in the service plan.
QC1C Service plan addresses the member's assessed needs	Set 1	**QC1C** Service plan addresses all identified needs. – Yes
		Not all identified needs were on the service plan. – No

		Service plan does not address any of the identified needs. – No
		Service plan was not provided to IME. – No
		Service plan identified needs that are not consistent with the member's abilities described on the assessment. - No
	Set 2	Service plan must address all identified needs of the member.
		Service plan includes services that were provided when the member was assessed to be independent in that area.
	Set 3	Recommend service plan be updated to address all identified needs.
		Recommend needs assessment be updated.
		Recommend new level of care review be initiated to determine accurate appropriate level of care.
		Recommend updating service plan to remove services that do not match an assessed need.

QC1D

QC1D

Service plan contains a plan for emergencies and supports available to the member in the event of a emergency	Set 1	Service plan contains an emergency plan. – Yes
		Service plan did not contain an emergency plan.– No
		Emergency plan does not address all identified risks. - No
	Set 2	Good documentation of an emergency plan is present in the service plan.
		Emergency plan must identify all identified risks.
	Set 3	Recommend emergency plan be documented in the service plan.
		Recommend emergency plan be updated to address identified risks.

QC1E

QC1E

Service plan addresses the member's personal goals.	Set 1	Service plan reflects individual personal goals. - Yes
		Service plan does not address personal goals. - No
		Goals were not provided to IME for review. - No
		Services are present without identified goals – No
	Set 2	Goals were written; however, they were not personalized.
		Goals are not current for this member.

All services must have an identified goal.

	Set 3	Recommend service plan be updated to include the member's personal goals. Recommend development of goals for all services.

QC1F

Service plan contains signature of member or guardian.

		QC1F
	Set 1	Service plan contains signature of member or guardian. - Yes
		Service plan is not signed by member or guardian. - No
	Set 2	Service plan must be signed by member or guardian.
	Set 3	Recommend service plan be signed by member or guardian.

QC1G

Service plan names all of the member's providers.

		QC1G
	Set 1	Documentation indicates the service plan lists all providers. – Yes
		Documentation indicates the service plan does not list all providers. - No Service plan only lists waiver providers and documentation indicates providers by other funding sources are not included. - No Unable to determine based on lack of documentation submission. - No
	Set 2	A service plan must list all providers who are providing services regardless of funding source and include natural supports.
	Set 3	Recommend updating service plan to list all providers and natural supports, regardless of funding source.

QC1H

Service plan lists the funding source for all services listed on the plan.

		QC1H
	Set 1	A funding source is listed for all services on the plan. -Yes
		All services listed on the plan do not have a funding source listed. - No Funding sources are not listed on the service plan for services. - No
	Set 2	All services must have a funding source listed on the service plan.
	Set 3	Recommend updating the service plan to list all funding sources.

QC1I

QC1I

Service plan lists the amount of services to be received by the member.	Set 1	All services listed indicate the amount of service to be received by the member. - Yes
		All services listed do not indicate the amount of services to be received by the member. - No
	Set 2	All service plans should indicate the amount of services to be received by the member.
	Set3	Recommend updating the service plan to indicate the amount of service to be received by the member.
QC1J Services identified on the service plan appear to be received by the member.		**QC1J**
	Set 1	All services listed appear to be received by the member.- Yes
		Services listed on the plan do not appear to be received by the member. - No
	Set 2	Verification should be completed ensuring the member is receiving all services identified in the service plan. Not all providers have submitted records to determine if services were provided. Unable to verify receipt of services.
	Set3	Recommend verification of services with member.

Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

[Worker_Name]
[Worker_Addr]
[Worker_City], [Worker_State] [Worker_Zip]

RE: [Member_Name] SID# [State_ID]

Dear Waiver Provider:

The Iowa Medicaid Enterprise (IME) Medical Services Unit conducts quality reviews of waiver provider records under contract with the Iowa Department of Human Services. The purpose is to perform a comprehensive review of all services received by randomly selected Medicaid members. However, a review was not conducted as no records were submitted to IME.

[Contact_Info]

Iowa Medicaid Enterprise
Medical Services

cc: [Worker_Supervisor]

470-4958 (8/10)

Iowa Medicaid Enterprise – 100 Army Post Road - Des Moines, IA 50315

RFP Reference:
6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:
N/A

Attachments:
N/A

MED - Long Term Care Waiver Quality Assurance Review Reporting

Purpose: To complete and submit reports to DHS on an adhoc basis. DHS Quality Assurance Specialist has access to all of the data collected. At times, specific data may be requested by Medical Services to submit.

Identification of Roles:
Program Specialist - Assembles data and positions data into report format

Manager - Reviews reports

Performance Standards:
- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days

Path of Business Procedure:
Step 1: Upon request of the department, the program specialist will utilize OnBase database and run queries to extract data.
Step 2: The program specialist will place data into approved report formats and submit to the manager as requested.
Step3: The manager will review reports and submit to DHS.

Forms/Reports:
Medical Services will provide ad hoc report data

RFP Reference:

6.2.6
6.2.6.1
6.2.6.2
6.2.6.3

Interfaces:

N/A

Attachments:

N/A

Attachment A:

Children's Mental Health Waiver Review

```
          ┌─────────────────────────┐
          │ Receive admission/annual│
          │ assessment and diagnosis│
          │       documents         │
          └───────────┬─────────────┘
                      │
          ┌───────────▼─────────────┐
          │  Evaluate information   │
          │       received          │
          │  (within 2 days for adm │
          │     5 days for CSR)     │
          └───────────┬─────────────┘
                      │
                      ▼
                  Sufficient          no       Obtain additional
                documentation?  ───────────►  information (ISIS,
                      │                       telephone, fax, e-mail)
                     yes                              │
                      │                               ▼
          Peer Review   no    Criteria/     ◄──   Additional
                   ◄────────   LOC met?           documentation
                      │                            received?
                     │           │
                  Approved?     yes
                      │          │
                     yes ──►  Enter approval
                      │        into ISIS
                     no            │
          ┌──────────────┐         ▼
          │  Deny LOC,   │──►  Complete LOC
          │ update ISIS  │      in OnBase
          └──────────────┘
```
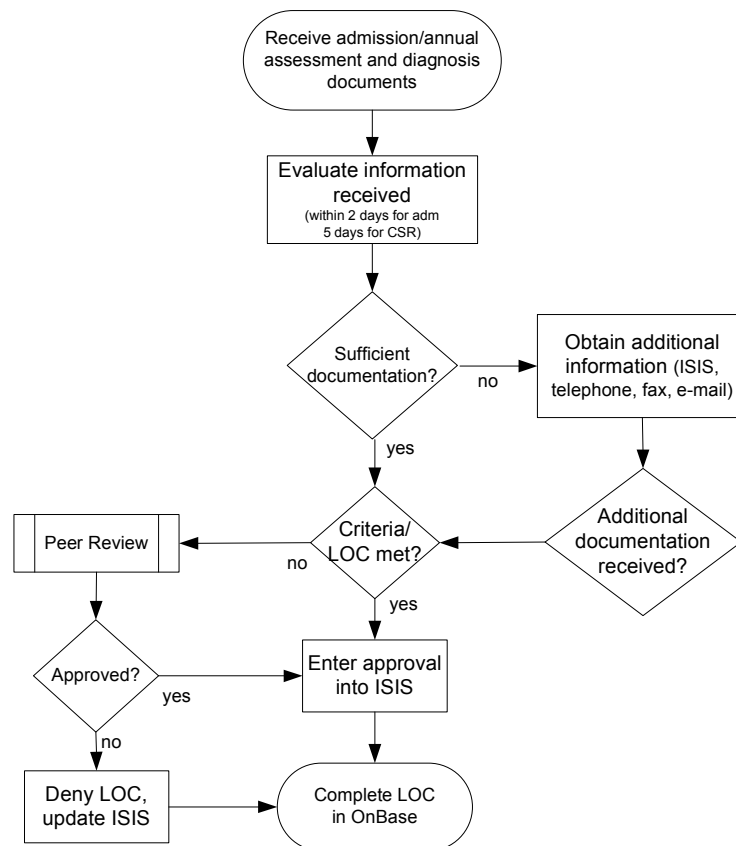
Attachment B:

Peer Review

```
                        ┌─────────────────┐
                        │ Specific program│
                        │     process     │
                        └─────────────────┘
                                 │
                                 ▼
        ◇ Consultation ◇   yes   ◇ Manager ◇    no   ┌──────────────────────┐
        ◇ with manager  ◇ ─────► ◇ supports need ◇ ─────►│ RC requests          │
        ◇   needed?     ◇        ◇   for PR?    ◇        │ additional information│
                 │                      │               │ or approves service  │
                 │ no                   │ yes           └──────────────────────┘
                 ▼                      │
        ┌─────────────────┐            │
        │ RC facilitates  │ ◄──────────┘
        │  peer review    │
        └─────────────────┘
```

| RC calls PR and presents case, documents in MQUIDS | RC completes PR form and e-mails PR | RC completes MD Router in OnBase | RA/RC completes PR form for delivery by courier |

```
                ◇ PR      ◇
        yes     ◇ approves? ◇
                      │ no
                      ▼
            ┌─────────────────┐
            │ RC facilitates  │
            │      NOD        │
            └─────────────────┘
                      │
                      ▼
            ╭─────────────────╮
            │ Complete review │
            │ using  specific │
            │ program process │
            ╰─────────────────╯
```

Attachment C:

ADMINISTRATIVE LAW JUDGE APPEALS